Pain Assessment Sheet

Name		File #		Date	

Current Complaints

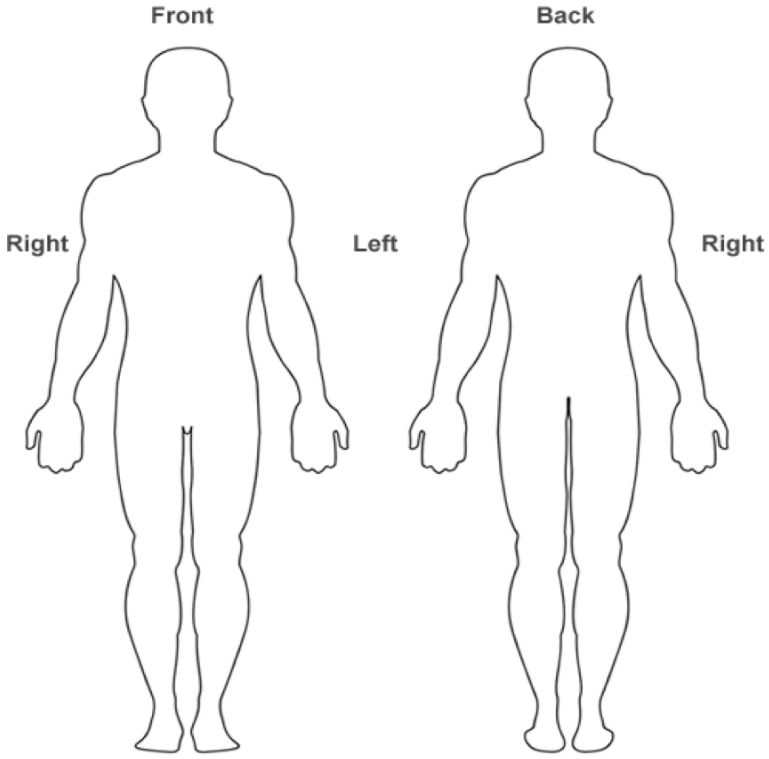
Progression of your current condition since it started	□ Same	□ Improved	□ Worse	□ Other

Does your present condition affect your daily activities at home or in the office? Describe:

Type of pain

□ Sharp	□ Tingling	□ Throbbing	□ Numbness	□ Aching	□ Shooting	□ Dull
□ Burning	□ Cramping	□ Stiffness	□ Swelling	□ Other _____		

Other comments and notes



Describe the areas where you feel pain and provide as much detail as possible. Mark the body outline to indicate location of pain.